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**Adjunctive laser or antimicrobial photodynamic therapy to non-surgical mechanical instrumentation in patients with untreated periodontitis.
A systematic review and meta-analysis.**

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Abstract

Aim: To compare the adjunctive effects of lasers or antimicrobial photodynamic therapy (aPDT) to non-surgical mechanical instrumentation alone in untreated periodontitis patients.

Materials and Methods: Two focused questions were addressed using the Population, Intervention, Comparison and Outcome criteria as follows: in patients with untreated periodontitis, i) does laser application provide adjunctive effects on probing pocket depth (PPD) changes compared with non-surgical instrumentation alone? and ii) does application of aPDT provide adjunctive effects on PPD changes compared with non-surgical instrumentation alone? Both randomized controlled clinical trials (RCTs) and controlled clinical trials (CCTs) were included. Results of the meta-analysis are expressed as weighted mean differences (WMD) and reported according to the PRISMA guidelines.

Results: Out of 1'202 records, 10 articles for adjunctive laser and 8 for adjunctive aPDT were included. With respect to PPD changes, 1 meta-analysis including 2 articles (total n=42; split-mouth design) failed to identify a statistically significant difference (WMD=0.35 mm; 95%CI:-0.04/0.73; p=0.08) in favour of adjunctive aPDT (wavelength range 650-700 nm). In terms of adjunctive laser application a high variability of clinical outcomes at 6 months was noted. Two articles included patient-reported outcomes and 10 reported on the presence/absence of harms/adverse effects.

Conclusions: Available evidence on adjunctive therapy with lasers and aPDT is limited by (i) the low number of controlled studies and (ii) the heterogeneity of study designs. Patient-reported benefits remain to be demonstrated.

1. Introduction

Non-surgical subgingival mechanical instrumentation aims at eliminating the etiologic factors on the root surface and is considered the standard of care of cause-related therapy in patients with untreated periodontitis (Badersten, Nilveus, & Egelberg, 1984a,b). Subgingival mechanical instrumentation may be performed by either hand and/or power-driven instruments and results in improved clinical outcomes such as reduced bleeding on probing (BoP) and decreased probing pocket depth (PPD) (Badersten et al., 1984a, b). However, in sites with impaired access such as deep periodontal pockets and furcation areas, residual subgingival calculus and bacterial deposits may remain on the root surface (Caffesse, Sweeney, & Smith, 1986; Oda & Ishikawa, 1989). Therefore, the adjunctive use of lasers and antimicrobial photodynamic therapy (aPDT) has been increasingly investigated as adjunctive approaches to non-surgical mechanical instrumentation alone (Schwarz, Aoki, Becker, & Sculean, 2008; Sgolastra, Severino, Gatto, & Monaco, 2013; Sgolastra, Severino, Petrucci, Gatto, & Monaco, 2014; Mizutani et al., 2016).

The most common laser applications for periodontal therapy include diode, carbon dioxide (CO₂), neodymium-doped: yttrium aluminium garnet (Nd:YAG), erbium-doped: yttrium aluminium garnet (Er:YAG) and erbium, chromium-doped: yttrium, scandium, gallium, garnet (Er,Cr:YSGG) lasers with wavelengths ranging from 635 to 10'600 nm. All of these wavelengths can be used adjunctively to mechanical non-surgical instrumentation to debride connective tissue and epithelium within periodontal pockets, inactivate bacteria and ablate subgingival calculus (Eberhard, Ehlers, Falk, Acil, Albers & Jepsen, 2003; Jepsen, Deschner, Braun, Schwarz & Eberhard, 2011). In fact, the Er:YAG laser with a wavelength of 2940 nm displays high absorption in water and hydroxide ions thereby providing the possibility to remove subgingival calculus without causing thermal side effects to adjacent tissue (Aoki, Ando, Watanabe, & Ishikawa, 1994; Eberhard et al., 2003; Schwarz et al., 2008). However, to be recommended for clinical applications, adjunctive use of any type of lasers to non-surgical mechanical instrumentation must yield predictable and safe outcomes superior to those obtained with mechanical instrumentation alone (Cobb, 2017).

An additional application of laser photons known as aPDT aims at destroying bacterial cells in periodontal pockets by means of highly reactive oxygen radicals produced by a combination of a low-level laser light in conjunction with a photosensitizer (Dobson & Wilson, 1992). Several oral bacteria are susceptible to low-level laser light in the presence of photosensitizers such as toluidine blue O, methylene blue and malachite green. This procedure is expected not only to reduce both the bacterial burden and inflammation in periodontal tissues but also to provide biostimulatory effects with photonic energy. Conflicting and short-term outcomes of clinical studies, however, were reported when comparing the adjunctive effects of aPDT to non-surgical mechanical instrumentation alone (Sgolastra et al., 2013; Pourabbas, Kashefimehr, Rahmanpour, Babaloo, Kishen, Tenenbaum & Azarpazhooh, 2014).

Despite reports of positive outcomes on the use of adjunctive lasers in the management of untreated periodontitis (Qadri, Javed, Johannsen & Gustafsson, 2015) and aPDT (Meimandi, Talebi Ardakani, Esmaeil Nejad, Yousefnejad, Saebi & Tayeed, 2017) in the management of untreated periodontitis, clinically relevant benefits for the patient need to be systematically appraised.

Hence, the aim of the present systematic review was to investigate the adjunctive effects of laser or aPDT to non-surgical periodontal therapy in patients with untreated periodontitis after a follow-up of 6 months.

2. Material and methods

2.1. Study registration

The review protocol was registered and allocated the identification number

CRD42019128262

in the PROSPERO international prospective register of systematic reviews hosted by the National Institute for Health Research (NIHR), University of York, UK, Center for Reviews and Dissemination.

2.2. Reporting format

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) were adopted throughout the process of the present systematic review (Moher et al., 2009; Moher et al., 2015).

2.3. Population (P), Intervention (I), Comparison (C) and Outcomes (O) (PICO)

Population: Patients with untreated periodontitis

Intervention: Adjunctive use of laser or aPDT to non-surgical mechanical instrumentation by means of hand and/or power-driven instrumentation

Comparison: Non-surgical mechanical instrumentation by means of hand and/or power-driven instrumentation alone

Outcome measures

Primary outcome

Change in PPD

Secondary outcomes

Change in clinical attachment level (CAL)

Residual PPD

Change in BoP

Change in plaque level

Change in subgingival biofilm composition

Change in gingival crevicular fluid (GCF) biomarker levels

Patient-reported outcome measures (PROMs)

Harms and adverse effects

2.4. Focused questions

The following focused questions were adapted using the PICO criteria (Stone, 2002):

- In patients with untreated periodontitis, does laser application provide adjunctive effects on PPD change compared with non-surgical mechanical instrumentation alone?
- In patients with untreated periodontitis, does application of aPDT provide adjunctive effects on PPD change compared with non-surgical mechanical instrumentation alone?

2.5. Search strategy

2.5.1. Electronic search

A comprehensive and systematic electronic search of MEDLINE via PubMed, Scopus and Cochrane Central Register of Controlled Trials (CENTRAL) databases was conducted for studies in humans published in English up to April 9th, 2019. Language was limited to English due to time constraints.

The following search terms were used:

PubMed search terms

For the search in the PubMed library, combinations of controlled terms (MeSH) and keywords were used whenever possible:

("periodontal diseases" [MeSH Terms] OR "periodontitis" [MeSH Terms]) AND ("laser" [All Fields] OR "photodynamic" [All Fields]) AND ("non-surgical" [All Fields] OR "non surgical" [All Fields] OR "scaling" [All Fields] OR "root planing"[All Fields] OR "debridement"[All Fields] OR "conventional periodontal therapy"[All Fields])

Scopus search terms

(KEY ("periodontal diseases" OR "periodontitis")) AND (TITLE-ABS-KEY ("laser" OR "photodynamic")) AND (TITLE-ABS-KEY ("non-surgical" OR "non-surgical" OR "scaling" OR root planing" OR "root planning" OR "debridement" OR "conventional periodontal therapy"))

Cochrane database for randomized controlled trials search terms

(MeSH descriptor: [Periodontitis] explode all trees OR MeSH descriptor: [Periodontal Diseases] explode all trees) AND (All text ("laser" OR "photodynamic")) AND (All text ("non-surgical" OR "non-surgical" OR "scaling" OR root planing" OR "debridement" OR "conventional periodontal therapy"))

2.5.2. Manual search

A manual search of the reference lists of relevant reviews and systematic reviews on the topics as well as of the reference lists of the included full-text articles was performed.

2.5.3. Unpublished literature search

In order to further identify potential articles for inclusion, grey literature was searched in the register of clinical studies hosted by the US National Institutes of Health (www.clinicaltrials.gov) and in the multidisciplinary European database (www.opengrey.eu).

2.6. Study design

The following study designs were considered:

- Randomized controlled clinical trials (RCTs)
- Prospective controlled clinical trials (CCTs)
- Studies with split-mouth and parallel arms designs

2.7. Inclusion criteria

The following inclusion criteria were applied:

- Follow-up of 6 months
- ≥ 20 patients per treatment arm at 6-month follow-up
- ≥ 20 patients at 6-month follow-up for studies with split-mouth design
- Clinical examination at 6-month follow-up
- Non-surgical instrumentation by means of hand and/or power-driven instruments
- Studies including subgingival adjunctive laser application
- For meta-analysis

- Studies including only 1x non-surgical mechanical instrumentation combined with only 1x adjunctive application of lasers or aPDT
- Studies reporting PPD changes between baseline and 6-month follow-up

2.8. Exclusion criteria

The following exclusion criteria were applied:

- Studies including patients with treated periodontitis
- Referred patients with pre-treated periodontitis
- Studies including patients treated in the course of supportive periodontal therapy (SPT)
- Studies including the use of ≥ 2 laser types
- Studies including a combination of laser and aPDT application
- Abstracts
- Letters to editors
- Narrative reviews
- Case reports
- Case series
- Insufficient/unclear informations not allowing data extraction
- No author response to inquiry e-mail for data clarification

2.9. Screening

Screening was performed independently by 4 reviewers (A. S., G. E. S., C. W. and J. C. S.). A Cohen's kappa score was calculated to assess inter-examiner agreement (Landis & Koch 1977) Eligibility assessment was performed firstly through title and abstract analysis and secondly through full-text analysis. In order to avoid exclusion of potentially relevant articles, abstracts providing unclear results were included in the full-text analysis. If necessary, authors were contacted for clarifications. From all studies of potential relevance, full-text was obtained for independent assessment by 2 reviewers against the stated inclusion criteria. Any disagreement was resolved by discussion among the reviewers. In the event of multiple publications on the same patient sample, relevant data

on the primary and secondary outcome measures were extracted from the publication with the 6-month follow-up.

2.10. Data extraction

From the selected articles fulfilling the inclusion criteria, data addressing the primary and secondary outcome measures were extracted in duplicate by two independent reviewers for qualitative and quantitative analysis.

2.11. Quality Assessment

The criteria used to evaluate the quality of the selected controlled trials were adopted from the checklist of the Cochrane Center and the CONSORT (Consolidated Standards of Reporting Trials) statement, providing guidelines for the following parameters: a) sequence generation; b) allocation concealment method; c) masking of the examiner; d) address of incomplete outcome data and e) free of selective outcome reporting. The degree of bias was categorized as low risk if all the criteria were met and high risk if two or more criteria were missing (Moher et al., 2010; Schulz, Altman, Moher, & Fergusson, 2010; Higgins, Altman, & Sterne, 2011). Potential impact of risk of bias for sample size calculation, patient selection, and reporting were considered for each selected study.

2.12. Data analysis

To assess changes in PPD (i.e. primary outcome) at the 6-month follow-up, mean values and standard deviations were used and analyzed with weighted mean differences (WMD) and 95% confidence intervals (CIs).

Results documenting PPD change were extracted from RCTs and used to evaluate the potential benefits of adjunctive laser or aPDT therapy. Meta-analyses were performed using random effect methods by grouping laser types according to their wavelength. For these meta-analyses, only studies using a single adjunctive application of laser or aPDT (test) and a single episode of non-surgical mechanical instrumentation (control) were included. Forest plots were used to illustrate the outcomes of the meta-analyses. Mean prediction intervals and their 95% lower and upper limits were only calculated and reported for meta-analyses including at least 3 studies.

The statistical heterogeneity among studies was explored by the I^2 index (Higgins et al., 2003).

Statistical significance was set to $p < 0.05$. All analyses were performed with Review Manager (RevMan Version 5.3. Copenhagen: The Nordic Cochrane Centre, The Cochrane Collaboration, 2014).

3. Results

3.1. Search

A total of 1'202 records were identified through the electronic search. After removal of duplicates, 659 records remained for abstract screening. No citations from the manual search and the grey literature search were identified (Figure 1).

Upon exclusion of 604 articles based on their abstracts, 55 articles remained for full-text evaluation. Following exclusion of 38 articles based on full-text analysis (Table 1), 17 articles remained for qualitative and quantitative analysis.

An inter-examiner Cohen's kappa score of 0.749 was calculated according to the results from title and abstract screening.

3.2. Adjunctive laser therapy

Description of included studies

The characteristics of the 10 articles evaluating the adjunctive use of laser are summarized in Table 2 (Üstün, Hatipoglu, Daltaban, Felek, & Firat, 2018; Matarese, Ramaglia, Cicciu, Cordasco, & Isola, 2017; Hatipoglu, 2017; Dereci, Hatipoglu, Sindel, Tozoglu, & Üstün, 2016; Dilsiz, Canakci, & Aydin, 2013; Euzebio Alves et al., 2013; Eltas & Orbak, 2012a; Kelbauskiene, Baseviciene, Goharkhay, Moritz, & Machiulskiene, 2011; Rotundo et al., 2010; Kamma, Vasdekis, & Romanos, 2009).

Study design

One article included two experimental and two control groups, respectively (Eltas & Orbak, 2012a). Two studies (Kamma et al., 2009; Rotundo et al., 2010) included 3 experimental and 1 control groups, respectively. One study included two experimental groups and one control group (Dilsiz et al., 2013) while the remaining 6 articles included one experimental group and one control group.

Three articles (Dereci et al., 2016; Hatipoglu et al., 2017; Üstün et al., 2018) reported on a parallel arm design while 7 articles reported on a split-mouth design (Dilsiz et al., 2013; Eltas & Orbak, 2012a; Euzebio Alves et al., 2013; Kamma et al., 2009; Kelbauskiene et al., 2011; Matarese et al., 2017; Rotundo et al., 2010).

The total number of patients treated was 370 of whom 230 were included in studies with a split-mouth and 140 in studies with a parallel arm design, respectively.

Study samples

Sample sizes varied from 24 to 60 patients and a power calculation was described in 5 of the 10 included articles (Euzebio Alves et al., 2013; Eltas & Orbak, 2012a; Kelbauskiene et al., 2011; Rotundo et al., 2010; Kamma et al., 2009).

The mean age of the included patients ranged from 34.9 to 50.5 years. The percentage of females ranged from 33 to 67% and of males from 33 to 66%, respectively. Smokers were reported in 3 articles (Kamma et al., 2009; Rotundo et al., 2010; Eltas & Orbak, 2012a) smokers were excluded in 6 articles (Kelbauskiene et al., 2011; Euzebio Alves et al., 2013; Dilsiz et al., 2013; Hatipoglu, 2017; Matarese et al., 2017; Üstün et al., 2018). Two articles reported on patients diagnosed with aggressive periodontitis (Kamma et al., 2009; Matarese et al., 2017), 7 articles on patients diagnosed with chronic periodontitis (Rotundo et al., 2010; Eltas & Orbak, 2012a; Dilsiz et al., 2013; Euzebio Alves et al., 2013; Hatipoglu et al., 2017; Dereci et al., 2016; Üstün et al., 2018) and periodontal diagnosis was not reported in 1 article (Kelbauskiene et al., 2011).

All studies were conducted in one center. One study (Kamma et al., 2009) was conducted in a private dental clinic limited to periodontics while the remaining 9 studies were conducted in a university setting.

Intervention/comparison

Five different types of laser were used in the 10 included articles. The use of a diode laser was reported in 4 articles (Kamma et al., 2009; Euzebio Alves et al., 2013; Matarese et al., 2017; Hatipoglu et al., 2017), Er:YAG laser in 1 article (Rotundo et al., 2010), Er,Cr:YSGG laser in 3 articles (Kelbauskiene et al., 2011; Dereci et al., 2016; Üstün et al., 2018), Nd:YAG laser in 1 article (Eltas & Orbak, 2012a) and potassium titanyl phosphate (KTP) laser in the remaining 1 article (Dilsiz et al., 2013).

In a total of 6 articles, non-surgical mechanical instrumentation and laser application was reported to be performed in one session (Üstün et al., 2018; Matarese et al., 2017; Hatipoglu et al., 2017; Eltas & Orbak, 2012a; Rotundo et al., 2010; Kamma et al., 2009) while in the remaining 4 articles (Euzebio Alves et al., 2013; Dilsiz et al., 2013;

Kelbauskiene et al., 2011, Dereci et al., 2016) non-surgical mechanical instrumentation and/or laser application was delivered in multiple sessions.

With respect to non-surgical mechanical instrumentation, 2 articles reported the use of hand instruments only (Kamma et al., 2009; Euzebio Alves et al., 2013) and the remaining 8 articles reported a combination of hand and power-driven instruments.

In 7 articles the use of local anesthesia in conjunction with periodontal treatment was reported (Üstün et al., 2018; Matarese et al., 2017; Hatipoglu et al., 2017; Dereci et al., 2016; Euzebio Alves et al., 2013; Eltas & Orbak, 2012a; Kamma et al., 2009), in 1 article local anesthesia was reported to be delivered if needed (Rotundo et al., 2010) whereas lack of information with respect to the use of local anesthesia was observed in 2 articles (Dilsiz et al., 2013; Kelbauskiene et al., 2011).

Outcomes

The outcomes of the 10 articles evaluating adjunctive laser therapy are summarized in Table 3. The data of the included RCTs provide an inconclusive picture regarding benefits of adjunctive laser application. Meta-analyses on the primary outcome measure could not be performed for lasers grouped with a wavelength range of 810-980 nm and a wavelength range of 2780-2940 nm due to (i) the low number of comparable studies, (ii) the heterogeneity of study designs and/or (iii) the lack of reporting of mean PPD changes between baseline and the 6-month follow-up in the original articles.

Table 6a summarizes the percentages of studies reporting on secondary outcomes. CAL change (i.e. 100%), Plaque Index change (i.e. 90%) and change in BoP (i.e. 90%) were reported with the highest frequency. Harms or adverse effects and change in subgingival biofilm composition were reported in 4 articles (i.e. 40%) while change in GCF biomarkers levels/volumes were reported in 3 articles (i.e. 30%). Residual PPD and PROMs were reported in 1 article (i.e. 10%).

3.3. Adjunctive aPDT

Description of included studies

The characteristics of the 8 included articles (Theodoro et al., 2012; Berakdar, Callaway, Eddin, Ross, & Willershausen, 2012; Dilsiz et al., 2013, Betsy, Prasanth, Baiju, Prasanthila, & Subhash, 2014; Malgikar et al., 2016; Al-Askar et al., 2017; Bundidpun,

Srisuwantha, & Laosrisin, 2018; Raut, Sethi, Kohale, Mamajiwala, & Warang, 2018) are summarized in Table 4.

Study design

All studies were designed as RCTs. Five out of 8 studies applied a split-mouth design, i.e. test and control interventions were compared within a patient (Theodoro et al., 2012; Berakdar et al., 2012; Dilsiz et al., 2013; Malgikar et al., 2016; Bundidpun et al., 2018). Three studies used 2 separate patient groups, i.e. non-surgical mechanical debridement without (control group) and with adjunctive aPDT treatment (test group) (Betsy et al., 2014; Al-Askar et al., 2017; Raut et al., 2018).

None of the included studies was funded by an industrial partner. Examiner calibration was reported in 6 articles (Theodoro et al. 2012; Dilsiz et al. 2013; Betsy et al. 2014; Al-Askar et al. 2017; Raut et al. 2018) (Malgikar et al. 2016). A formal power calculation was described in 5 (Theodoro et al., 2012; Betsy et al., 2014; Al-Askar et al., 2017; Raut et al., 2018) (Bundidpun et al. 2018) of the 8 included articles.

All studies were conducted in a single university or specialist center.

Study samples

Samples sizes varied from 20 to 88 patients. The total number of patients observed was 331, i.e. 123 patients received test and control interventions in a split-mouth design, and 208 patients received either mechanical debridement without (104 patients as controls) or with adjunctive aPDT treatment (104 patients as test group). Mean age of included patients ranged from 41 to 59 years, and the proportion of females varied from 0 to 65%.

In all studies, patients with systemic conditions, pregnant or lactating women and patients who had taken antibiotics in the past 3 to 12 months were excluded. One study included exclusively patients with medically diagnosed prediabetes (Al-Askar et al., 2017). Smoking was an exclusion criterion in all studies.

Dental and periodontal characteristics of the patients included varied considerably between studies. While case definitions and requirements in terms of PPD differed among studies, in all studies but 1 (Al-Askar et al. 2017) patients were diagnosed with

chronic periodontitis according to the 1999 classification (Armitage, 1999). Nine articles specified a minimum of PPD ≥ 4 to 7mm in at least 3 to 6 teeth or sites. One article defined the presence of PPD > 5 mm and CAL > 4 mm without definition of a minimum number of teeth (Raut et al. 2018). Three articles (Theodoro et al., 2012; Dilsiz et al., 2013; Berakdar et al. 2012) called for the presence of BoP. Five articles defined the presence of at least 20 teeth (Theodoro et al., 2012; Dilsiz et al., 2013; Betsy et al., 2014; Malgikar et al., 2016; Bundidpun et al., 2018)

The number of tooth sites treated with adjunctive aPDT (test procedure) ranged from 33 to 839 sites. Four articles did not specify the exact number of teeth or sites treated per patient and/or treatment arm (Dilsiz et al., 2013; Malgikar et al., 2016; Al-Askar et al., 2017; Raut et al., 2018). In 4 articles, treated sites were specified in terms of PPD and the presence of BoP (Theodoro et al., 2012; Berakdar et al., 2012; Betsy et al., 2014; Al-Askar et al., 2017). One article reported exclusively single-rooted teeth in the analysis (Betsy et al., 2014).

Intervention/comparison

A diode laser was used in the 8 articles included. All articles but 1 (Raut et al., 2018) stated the laser manufacturer which differed among studies. The most commonly used laser tips were fiber optic tips (Theodoro et al., 2012; Dilsiz et al., 2013; Betsy et al., 2014; Malgikar et al., 2016; Bundidpun et al., 2018). In the remaining three articles, the material of the laser tip was not reported. If reported, diameter of the laser tip ranged from 200 to 400 μ m. The output power of the lasers ranged from 30 to 1000mW with an irradiation time of 10 to 150s per site. Wavelengths of lasers ranged from 655 to 980nm. In 3 articles, laser densities were reported, and ranged from 5.4 to 60J/cm² (Theodoro et al., 2012; Betsy et al., 2014; Raut et al., 2018).

Five articles reported the application of methylene blue in different concentrations as photosensitizer, while three articles (Theodoro et al., 2012; Bundidpun et al., 2018; Raut et al., 2018) reported the use of toluidine blue O, phenothiazine chloride or indocyanine green for laser activation. Application time of the photosensitizer per site amounted to 1 minute (Bundidpun et al., 2018; Raut et al., 2018) or 3 minutes (Dilsiz et al., 2013; Betsy et al., 2014; Malgikar et al., 2016), if reported.

All studies included test and control groups. In both groups, non-surgical mechanical instrumentation was performed by hand instruments, i.e. curettes (Berakdar et al., 2012; Theodoro et al., 2012), or power-driven instruments, i.e. ultrasonic devices (Al-Askar et al., 2017; Bundidpun et al., 2018), or a combination of both (Dilsiz et al., 2013; Betsy et al., 2014; Malgikar et al., 2016; Raut et al., 2018). In all studies but 1 (Dilsiz et al., 2013), non-surgical mechanical instrumentation was performed in one single session. Five articles reported full-mouth instrumentation (Dilsiz et al., 2013; Betsy et al., 2014; Malgikar et al., 2016; Al-Askar et al., 2017; Bundidpun et al., 2018). Treatment in controls consisted of non-surgical mechanical instrumentation without adjunctive measures. In 2 studies, a placebo laser was additionally used in the control group (Dilsiz et al. 2013; Raut et al., 2018). Treatment in the test groups consisted of non-surgical mechanical instrumentation with adjunctive aPDT, which was applied immediately after mechanical instrumentation in 5 studies (Berakdar et al., 2012; Theodoro et al., 2012; Betsy et al., 2014; Al-Askar et al., 2017; Raut et al., 2018). In 3 studies, aPDT was applied with a time lag after mechanical instrumentation, i.e. after 24 h (Malgikar et al., 2016) or 1 week (Dilsiz et al., 2013; Bundidpun et al., 2018). In all studies, aPDT was applied once. In all studies, maximum follow-up time amounted to 6 months. None of the included articles reported on PPD measurements and/or subgingival mechanical debridement within 6 months after initial treatment. Oral hygiene instructions and/or professional prophylaxis were performed after 1, 3 and 6 months in 3 studies (Dilsiz et al., 2013; Malgikar et al., 2016; Bundidpun et al., 2018) and in weekly to monthly intervals in 1 study (Theodoro et al., 2012).

Outcomes

The outcomes of the 8 studies evaluating the adjunctive use of aPDT are summarized in Table 5. In order to conduct meta-analyses on reported mean PPD changes between baseline and the 6-month follow-up, studies were grouped according to wavelength, frequency of mechanical instrumentation (i.e. only 1x) and frequency of aPDT application (i.e. only 1x). Based on the small number of studies in the meta-analysis (i.e. <10), funnel plots were not included to display publication bias.

Primary outcome: Change in PPD

Five studies were excluded from meta-analysis based on the fact that treatment was repeated after one week (Dilsiz et al., 2013), mean PPD changes were not reported (Raut et al., 2018; Theodoro et al., 2012), mean PPD values were not reported (Betsy et al., 2014) and only treated sites with PPD ≥ 4 mm were reported (Al Askar et al., 2017).

Figure 2 illustrates the results of the meta-analysis for changes in PPD based on 2 studies with split-mouth design including a total of 42 patients (Bundidpun et al., 2018; Berakdar et al., 2012). No statistically significant difference (WMD=0.35 mm; 95%CI:-0.04/0.73; p=0.08) was observed comparing adjunctive use of aPDT (wavelength range: 650-700 nm) to non-surgical periodontal therapy alone.

Secondary outcomes

Table 6b summarizes the percentages of studies reporting on secondary outcomes. Changes in Plaque Index were reported in all studies. CAL changes and the report of harms or adverse effects represented the second most cited outcomes (i.e. 88%) followed by BoP changes (i.e. 75%). Changes in subgingival biofilm composition were reported in 25% of articles. Patient-reported outcome measures and residual PPD were reported in 1 article each (i.e. 13%) and no article reported on changes in GCF biomarker levels/volumes.

3.4. Quality assessment

The assessment of risk of bias of the included studies is illustrated in Table 7a+b and was based on the Cochrane Center and CONSORT guidelines (Consolidated Standards of Reporting Trials) to evaluate the quality of RCTs (Moher et al., 2010; Schulz et al., 2010). No single study demonstrated high risk of bias and the majority of studies displayed a low or unclear risk of bias.

4. Discussion

The aim of the present systematic review was to investigate the adjunctive effects of laser application or aPDT to non-surgical periodontal therapy of at least 20 patients with untreated periodontitis after a follow-up of 6 months. It should be noted that studies reporting on laser application or aPDT as a monotherapy as well as studies conducted in treated periodontitis patients and in patients enrolled in supportive periodontal therapy were not considered for the present systematic review. Moreover, studies reporting on the use of airpolishing devices were not considered as it is not regarded the standard of care for untreated periodontitis patients.

The adjunctive use of lasers with 8 different wavelengths was identified. The potential benefits compared to control procedures were evaluated in 10 studies with a total of 370 patients for adjunctive laser therapy and in 8 studies with a total of 331 patients for adjunctive aPDT. The results of one meta-analysis including 2 studies with split-mouth design indicated that adjunctive aPDT application to non-surgical periodontal therapy failed to yield statistically significant improvements with respect to mean PPD changes between baseline and the 6-month follow-up.

The term “untreated periodontitis” was selected in order to differentiate adjunctive application of lasers or aPDT between patients with untreated periodontitis and those enrolled in supportive periodontal therapy. Moreover, a potential wash-over effect could not be completely ruled out when applying aPDT in studies with a split-mouth design and may bias the outcomes.

In addition, keeping in mind the observed great heterogeneity among the studies identified by the systematic search, in particular in terms of laser type, tip diameter, wavelength, photosensitizer, mode of periodontal treatment, number of treated sites, population and several possible combinations of these parameters, a careful attempt was developed to conduct meta-analyses only when PPD changes between baseline and the 6-month follow-up were reported in the original articles. Within the highly heterogeneous set of confounding variables, a selection of parameters including wavelength, type of laser, single episode of non-surgical periodontal therapy and single application of laser/aPDT for grouping the studies was considered and applied for further analysis in case studies were suitable.

Two articles included PROMs and 10 articles reported the presence/absence of harms or adverse effects. Nine studies did not observe any adverse or side effects (Kelbauskiene et al., 2011; Bundidpun et al., 2018; Dilsiz et al., 2013; Berakdar et al., 2012; Malgikar et al., 2016; Betsy et al., 2014; Raut et al., 2018; Theodoro et al., 2012; Dereci et al., 2016). In one study, two periodontal abscesses occurred in the test group (Rotundo et al., 2010).

All but 1 study (Kamma et al., 2009) were performed in a university setting. Interestingly, no study reported on cost/benefit ratio related to adjunctive laser/aPDT application.

The results of the present systematic review are in accordance with those presented in recent narrative reviews on the topic (Mizutani et al., 2016; Cobb, 2017). Collectively, available evidence is limited and highly heterogeneous.

If both statistical and clinical significance are considered to be equally important when comparing adjunctive laser therapy or aPDT to non-surgical mechanical instrumentation alone, future RCTs should define which criteria determine clinical significance. Defining PPD changes as the primary outcome has some limitations. The reporting of the percentage of PPDs ≤ 5 mm or the percentage of PPDs > 5 mm would be meaningful from a clinical perspective. Unfortunately, only one study on adjunctive lasers and one study on adjunctive aPDT reported on residual PPDs. This is of critical importance when planning dissemination of evidence-based guidelines for periodontal therapy. In this context, guidelines for periodontal therapy should include a list of criteria for the assessment of (i) thresholds of reduction in PPD, BoP and gain in CAL, (ii) percentage of residual PPD > 5 mm requiring additional periodontal therapy, (iii) frequency distribution of sites exhibiting a substantial improvement from baseline with respect to PPD, BoP and CAL, (iv) harms and adverse events, (v) PROMs and (vi) costs of treatment. Ideally, future studies should adopt the CONSORT guidelines, apply sufficient statistical power, use appropriate randomization and avoid split-mouth designs.

It is well known that smoking adversely affects periodontal treatment outcomes. Therefore the results of studies with adjunctive laser application including smokers (Kamma et al., 2009; Rotundo et al., 2010) need to be interpreted accordingly. Furthermore, clinicians should be aware that the evidence on the effects of adjunctive therapy with different types of lasers or aPDT is affected by a number of factors such as: (i) the variation in diagnosis and risk profiles of patients with untreated periodontitis, (ii)

the variation in protocols and frequency of non-surgical mechanical instrumentation, (iii) the variation in laser types/wavelengths, (iv) the variation in aPDT protocols, and (v) the variation in frequency of application of adjunctive laser or aPDT. Hence, in patients with untreated periodontitis, current evidence on the adjunctive use of lasers or aPDT to non-surgical periodontal therapy is limited and heterogeneous.

Clinical relevance

Scientific rationale for review: Periodontitis is a biofilm-initiated disease and its treatment is accomplished by means of non-surgical mechanical instrumentation. The aim of the present systematic review was to investigate whether or not adjunctive application of laser or antimicrobial photodynamic therapy (aPDT) provides benefits to non-surgical periodontal therapy alone after a follow-up of 6 months.

Principal findings: Evidence on adjunctive therapy with laser or aPDT is limited and heterogeneous. One meta-analysis based on 2 articles (total n=42; split-mouth design) failed to identify a statistically significant difference (WMD=0.35 mm; 95%CI:-0.04/0.73; p=0.08) in mean PPD changes in favour of adjunctive aPDT with a wavelength range of 650-700 nm.

Out of 17 articles, 2 reported on patient-reported outcome measures and 10 reported on presence/absence of harms or adverse effects.

Practical implications: Available evidence on adjunctive therapy with lasers and aPDT is limited by (i) the low number of controlled studies and (ii) the heterogeneity of study designs. A high variability of clinical outcomes at 6 months was noted. Patient-reported benefits remain to be demonstrated.

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Conflict of interest

The authors do not report any conflicts of interest.

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Tables

Table 1. Studies excluded based on full-text analysis and reasons for exclusion.

First author (year of publication)	Reason for exclusion
Abduljabbar et al. 2017	4*
Al-Falaki et al. 2016	3
Angelov et al. 2009	6*
Balata et al. 2013	4*
Castro Dos Santos et al. 2016	3
Ciurescu et al. 2016	3
Crespi et al. 2007	3
Derdilopoulou et al. 2007	4
Dilsiz & Sevinc 2014	5
Eltas & Orbak 2012b	5
Franco et al. 2014	1
Giannelli et al. 2012	3
Giannelli et al. 2015	3
Giannelli et al. 2018	3
Grzech et al. 2018a	3
Grzech et al. 2018b	3
Gündogar et al. 2016	3
Hill et al. 2019	4*
Moritz et al. 1998	1
Obradodovic et al. 2012	4
Pesevska et al. 2017	4
Petrovic et al. 2018	2
Pinheiro et al. 2010	1
Qadri et al. 2011	5
Romero et al. 2017	3
Roncati et al. 2017	1
Ruiz Magaz et al. 2016	4*
Saglam et al. 2014	1

Salgado et al. 2017	1
Sanz-Sanchez et al. 2015	1
Schwarz et al. 2001	3
Schwarz et al. 2003a	3
Schwarz et al. 2003b	3
Sculean et al. 2004	3
Segarra-Vidal et al. 2017	1
Sjöström & Friskopp 2002	2
Üstün et al. 2014	1
Yadwad et al. 2017	3
1, number of subjects < 20; 2, follow-up time < 6 months; 3, study protocol does not match with stated focused question; 4, endpoints do not match with stated inclusion criteria; 5, no data at 6-month follow-up; 6, other reasons (e.g. follow-up time unknown); * no author response to inquiry e-mail for data clarification	

Table 2. Characteristics of studies on adjunctive laser therapy to non-surgical mechanical instrumentation.

First author (year)	Study	Patient characteristics	Laser	Physical data	Treatment	Follow-up
	type design	n patients (n female)	laser type (product name)	laser power		time points (mo)
	n center	mean age \pm SD (range)	material of tip (diameter)	laser energy		treatment
	industrial funding	periodontal diagnosis		irradiation time		adverse effects
	calibration	smoking status		wavelength		
		n treated teeth/sites per treatment arm		laser intensity		
		type of probe		laser density		
		sites of probing per tooth				
Kamma et al. (2009)	RCT split-mouth single-center	30 patients (16 female) 41.8 \pm 6.2 AgP 18 smokers, 12 non-smokers	diode laser (SmilePro980™, Biolitec, Jena, Germany)	2 W n.r. 30 s/site 980 nm	test group: SRP (hand) + laser	2 weeks – 3 – 6 n.r.
	none	one quadrant per patient (1 site per treatment group per patient analyzed)	flexible glass fiber optic guide (300 μ m)	2830 W/cm ² 94.3 J/cm ²	control group: SRP (hand)	n.r.
	examiner calibrated	Goldman/Fox-Williams 6				
Rotundo et al. (2010)	RCT split-mouth single-center	27 patients* (18 female) 50.5 \pm 11.7 ChP 12 smokers (<10 cigarettes/day), 15 non-smokers	Er:YAG laser (Smart 2940 Plus, DEKA M.E.L.A. srl, Calenzano, Firenze, Italy)	n.r. n.r. n.r. 2940 nm	test group: laser + SRP (hand + ultrasonic)	3 – 6 SPT after 1 week, 1, 3 and 6 mo
	none		conic fiber tip (0.5 mm)	n.r. 150 mJ/pulse at 10 Hz	control group: SRP (hand + ultrasonic)	2 periodontal abscesses in the test group, 1 patient with fever, 1 patient lost 1 day of work, 1 patient with 1 day of daily-life interference
	examiner calibrated	419 sites for test and 422 sites for control group; one quadrant per patient [§] n.r. 6				
Kelbauskienė et al. (2011)	RCT split-mouth single-center	30 patients (14 female) n.r. (26-58) early or moderate periodontitis non-smokers	Er,Cr:YSGG laser (Waterlase, Biolase, Culver City, USA)	1 W n.r. n.r. 2780 nm	test group: SRP (hand + ultrasonic) + laser**	2 – 3 – 6 – 12 OHI, supragingival scaling and polishing
	n.r.	143 teeth for control and 135 teeth for test group mean 8.4 (1.3) teeth per patient for control and mean 9.5 (2.2) teeth for test group (single-rooted teeth) ^{§§} PCP 12 (Hu-Friedy, USA) 6	fiber optic tip (600 μ m)	n.r.	control group: SRP (hand + ultrasonic)	none
	examiner calibrated					
Eltas and Orbak (2012a)	RCT split-mouth single-center	52 patients (26 female) 43.5 (32-52) ChP 26 smokers, 26 non-smokers	Nd:YAG laser (n.r.)	1 W, 10 Hz 100 mJ 30 s/site 1064 nm	test group: SRP (hand + ultrasonic) + laser	1 – 6 n.r.
	none	104, i.e. 2 teeth per patient	fiber optic tip (n.r.)	n.r.	control group: SRP (hand + ultrasonic) + placebo laser	n.r.
	examiner calibrated	n.r. 6		n.r.		
Dilsiz et al. (2013) ^e	RCT split-mouth single-center	24 patients (14 female) 40.7 \pm 7.3 (30-58) ChP non-smokers	KTP laser (SmartLite, DEKA, Florence, Italy)	0.8 W n.r. n.r. 532 nm	test group: SRP in two sessions within 7 days (ultrasonic and hand) + laser	6 prophylaxis after 1 and 3 mo
	none	144 teeth distributed over three treatment groups	fiber optic tip (200 μ m)	n.r. 11.7 J/cm ²	control group: SRP in two sessions within 7 days (ultrasonic and hand) + placebo laser	none
	examiner calibrated	Florida Probe (Gainesville, USA) with an occlusal stent n.r.				
Euzebio Alves et al. (2013)	RCT split-mouth single-center	36 patients (23 female) 46.8 \pm 8.11 (37-64) ChP non-smokers	diode laser (ZAP Softlase, Pleasant Hill, USA)	1.5 W n.r. 20 s/site 808 \pm 5 nm	test group: SRP (hand) + laser (2 applications: 1 day and 1 week after SRP)	1.5 – 6 SPT at 3 mo
	none	36 (single-rooted tooth)	fiber optic tip (400 μ m)	1193.7 W/cm ² n.r.	control group: SRP (hand) + placebo laser	n.r.
	examiner calibrated	PCPUNC 15 (Hu-Friedy) 6				
Dereci et al. (2016)	RCT parallel arms single-center	60 patients (29 female) 43.7 \pm 3.1 ChP n.r.	Er,Cr:YSGG laser (Biolase, Irvine, California, USA)	1.5 W, 30 Hz n.r. n.r.	test group: SRP (hand + ultrasonic) 1 time + laser, 3 times within 7 days	1 – 3 – 6 n.r.
	none	n.r.	fiber optic tip RFPT 5-14 (n.r.)	n.r. n.r.	control group:	none

	n.r.	Williams 6			SRP (hand + ultrasonic) 3 times within 7 days + placebo laser	
Hatipoglu et al. (2017)	RCT parallel arms single-center	40, (20 ^a /20 ^b) (20 female) n.r. ChP non-smokers	indium-gallium-aluminium- phosphate diode laser (Epic, Biolase, Irvine, CA, USA)	1.5 W n.r. 20 s/tooth 940 nm	test group: SRP (hand + ultrasonic) + laser	1 – 3 – 6 n.r.
	n.r.	n.r.	fiber optic tip (300 µm)	n.r. 15 J/cm ²	control group: SRP (hand + ultrasonic)	n.r.
	n.r.	n.r. 6				
Matarese et al. (2017)	RCT split-mouth single-center	31 patients (17 female) 34.9 ± 1.2 AgP non-smokers	diode laser (Wiser Laser, Doctor smile, Lambda, Vicenza, Italy)	1 W, 50 Hz n.r. 20 s/tooth 810 nm	test group: SRP (ultrasonic) + laser	0.5 – 1 – 2 – 6 – 12 n.r.
	none	n.r. (one maxillary quadrant with at least 6 teeth per patient) UNC-15 (Hu-Friedy, USA) 6	fiber optic tip (300 µm)	n.r. 24.84 J/cm ²	control group: SRP (ultrasonic) + placebo gel solution	n.r.
	examiner calibrated					
Üstün et al. (2018)	RCT parallel arms single-center	40, (20 ^a /20 ^b) (19 female) 45.8 ± 6.53 (36-59) ^a , 44.05 ± 6.16 (35-58) ^b ChP	Er,Cr:YSGG laser (Waterlase iplus, Biolase, Irvine, CA, USA)	1.5 W, 30 Hz n.r. n.r. n.r.	test group: SRP (hand + ultrasonic) + laser	1 – 3 – 6 supragingival cleaning after 1, 3 and 6 mo
	none	non-smokers	fiber optic tip RFPT 5-14 (n.r.)	n.r.	control group: SRP (hand + ultrasonic)	n.r.
	n.r.	n.r. PWD (Hu-Friedy, USA) 6				

AgP, aggressive periodontitis; ChP, chronic periodontitis; Er:YAG, erbium-doped: yttrium aluminium garnet; Er,Cr:YSGG, erbium, chromium-doped: yttrium, scandium, gallium and garnet; GaAlAs, aluminium-gallium-arsenide; KTP, potassium-titanyl-phosphate; n, number; n.r., not reported; Nd:YAG, neodymium-doped: yttrium aluminium garnet; mo, months; OHI, oral hygiene instructions; SRP, scaling and root planning; SPT, supportive periodontal therapy; ^a, test group; ^b, control group; ^c study has 2 test groups see table 4; *, 1 patient lost to follow-up (26 patients were included in the analyses); **, laser application once a week for each millimeter of pocket reduction (on average 3 appointments); [§] finally analyzed: 405 sites for test and 399 for control group; ^{§§} finally analyzed: 509 for test and 579 for control group.

Table 3. Clinical outcome parameters of studies on adjunctive laser therapy to non-surgical mechanical instrumentation. If not otherwise indicated, parameters are presented as means \pm standard deviation.

First author (year)	Group	Time point	PPD (mm)	PPD change (mm)	CAL (mm)	CAL change (mm)	BOP (%)	BOP change (%)	PI (%)
Kamma et al. (2009)	test	baseline	6.67 \pm 1.29	-	7.07 \pm 1.71	-	82.4	-	52.7
		6 mo	3.87 \pm 0.92*	-	4.93 \pm 1.62*	-	24.3	-	29.2
	control	baseline	6.47 \pm 1.36	-	7.07 \pm 1.58	-	81.6	-	54.1
		6 mo	4.13 \pm 1.06*	-	5.20 \pm 1.66*	-	25.8	-	32.6
Rotundo et al. (2010)	test	baseline	5.1 \pm 1.1	-	5.7 \pm 1.5	-	71	-	63
		6 mo	3.9 \pm 1.5	1.2 \pm 1.6	5.2 \pm 1.8	0.5 \pm 1.7	53	-	47
	control	baseline	5.2 \pm 1.2	-	6.1 \pm 1.6	-	73	-	68
		6 mo	4.3 \pm 1.7	1.0 \pm 1.5	5.6 \pm 2.0	0.5 \pm 1.8	57	-	48
Kelbauskienė et al. (2011)	test	baseline	4.33 \pm 1.08**	-	4.47 \pm 1.2**	-	79.0	-	3.5 ^a
		6 mo	-	2.13 \pm 1.24**	-	2.1 \pm 1.26**	10.5	-	9.1 ^a
	control	baseline	4.07 \pm 0.79**	-	4.23 \pm 0.92**	-	74.1	-	3.7 ^a
		6 mo	-	1.64 \pm 1.06**	-	1.57 \pm 1.11**	17.0	-	14.1 ^a
Eltas and Orbak (2012a)	test ^b	baseline	5.4 \pm 0.8	-	6.7 \pm 1.1	-	-	-	1.9 \pm 0.6 ^d
		6 mo	3.8 \pm 0.6	-	6.4 \pm 1.1	-	-	-	0.8 \pm 0.5 ^d
	control ^b	baseline	5.4 \pm 0.7	-	6.6 \pm 1.2	-	-	-	1.7 \pm 0.6 ^d
		6 mo	4.2 \pm 0.5	-	6.5 \pm 1.1	-	-	-	0.7 \pm 0.5 ^d
	test ^c	baseline	5.3 \pm 0.7	-	6.1 \pm 1.1	-	-	-	1.7 \pm 0.8 ^d
		6 mo	3.1 \pm 0.5*	-	5.6 \pm 1.0	-	-	-	0.6 \pm 0.4 ^d
	control ^c	baseline	5.3 \pm 0.8	-	6.1 \pm 0.9	-	-	-	1.8 \pm 0.5 ^d
		6 mo	3.6 \pm 0.5*	-	5.8 \pm 1.0	-	-	-	0.6 \pm 0.5 ^d
Dilsiz et al. (2013)	test	baseline	5.96 \pm 0.91	-	7.75 \pm 0.61	-	96 \pm 0.20	-	1.42 \pm 0.58 ^e
		6 mo	3.92 \pm 0.41*	2.08 \pm 1.02	5.33 \pm 1.05*	2.42 \pm 1.14	42 \pm 0.50	-	0.75 \pm 0.44 ^e
	control	baseline	5.83 \pm 0.76	-	7.50 \pm 0.72	-	92 \pm 0.28	-	1.46 \pm 0.51 ^e
		6 mo	4.42 \pm 0.88*	1.42 \pm 0.88	6.04 \pm 1.00*	1.50 \pm 0.88	46 \pm 0.51	-	0.71 \pm 0.46 ^e
Euzebio Alves et al. (2013)	test	baseline	6.13 \pm 1.35	-	6.91 \pm 1.94	-	97.2 \pm 16.6	-	1.25 \pm 0.99 ^d
		6 mo	3.63 \pm 1.49	2.56 \pm 1.79	5.33 \pm 2.13	1.70 \pm 1.72	40.1 \pm 49.3	57.1	0.66 \pm 0.88 ^d
	control	baseline	5.69 \pm 0.95	-	6.50 \pm 1.74	-	94.4 \pm 23.2	-	1.47 \pm 0.90 ^d
		6 mo	2.93 \pm 1.33	2.76 \pm 1.13	4.30 \pm 2.08	2.10 \pm 1.64	33.6 \pm 47.2	60.8	0.60 \pm 0.77 ^d
Dereci et al. (2016)	test	baseline	5.3 \pm 1.8	-	2.9 \pm 0.6	-	75.1 \pm 7.2	-	2.4 \pm 0.5 ^e
		6 mo	1.9 \pm 0.7	-	1.8 \pm 0.5	-	37.8 \pm 7.7*	-	1.5 \pm 0.5 ^e
	control	baseline	5.3 \pm 1.8	-	2.9 \pm 0.4	-	77.7 \pm 7.4	-	2.5 \pm 0.5 ^e
		6 mo	2.1 \pm 0.6	-	1.9 \pm 0.4	-	41.6 \pm 8.6*	-	1.5 \pm 0.5 ^e
Hatipoglu et al. (2017)	test	baseline	4.05 \pm 0.64	-	3.03 \pm 0.65	-	75.9 \pm 6.79	-	1.88 \pm 0.27
		6 mo	1.88 \pm 0.55	-	1.75 \pm 0.58	-	21.7 \pm 8.16*	-	1.25 \pm 0.15*
	control	baseline	4.00 \pm 0.53	-	2.74 \pm 0.59	-	74.8 \pm 7.59	-	1.86 \pm 0.28
		6 mo	1.95 \pm 0.81	-	1.81 \pm 0.60	-	31.5 \pm 7.23*	-	1.41 \pm 0.16
Matarese et al. (2017)	test	baseline	5.25 \pm 0.66	-	5.36 \pm 0.39	-	75.26 \pm 3.6	-	28.21 \pm 5.12
		6 mo	2.24 \pm 0.35	-	3.19 \pm 0.22	-	22.79 \pm 4.2	-	24.55 \pm 3.36
	control	baseline	5.18 \pm 0.57	-	4.88 \pm 0.55	-	78.12 \pm 2.2	-	28.54 \pm 5.23
		6 mo	2.68 \pm 0.29	-	3.11 \pm 0.25	-	24.67 \pm 3.2	-	25.04 \pm 3.69
Üstün et al. (2018)	test	baseline	3.88 \pm 0.50	-	2.69 \pm 0.47	-	74.75 \pm 7.59	-	1.72 \pm 0.32
		6 mo	1.83 \pm 0.80	-	1.76 \pm 0.56	-	26.85 \pm 7.39	-	1.32 \pm 0.16
	control	baseline	3.97 \pm 0.72	-	2.88 \pm 0.58	-	77.30 \pm 7.64	-	1.78 \pm 0.35
		6 mo	2.03 \pm 0.73	-	1.76 \pm 0.57	-	32.70 \pm 7.55	-	1.21 \pm 0.15

BOP, bleeding on probing; CAL, clinical attachment loss; PI, plaque index; PPD, probing pocket depth; *, p<0.05; **, p<0.001; ^a, percentage of teeth presenting visible plaque; ^b, smokers; ^c, non-smokers; ^d, according to Silness & Loe (1964); ^e, according to Loe (1967).

Table 4. Characteristics of studies on adjunctive aPDT to non-surgical mechanical instrumentation.

First author (year)	Study	Patient characteristics	Laser	Physical data	Treatment	Follow-up
	type	n patients (n female)	laser type (product name)	laser power		time points (mo)
	design	mean age \pm SD (range)		laser energy		
	n center	periodontal diagnosis	material of tip (diameter)	irradiation time		supportive therapy
		smoking status		wavelength		
	industrial		photosensitizer	laser intensity		adverse effects
	funding	n treated teeth/sites per treatment arm	application time/site	laser density		
	calibration	sites of probing per tooth				
Berakdar et al. (2012)	RCT split-mouth single-center	22 patients (10 female) 59.3 \pm 11.7 (38-74) ChP non-smokers	diode laser (Periowave, Ondine Biopharma, Vancouver, Canada)	150 mW n.r. 60 s 670 nm n.r.	test group: SRP (hand) + aPDT control group: SRP (hand)	1 – 3 – 6 n.r. none
	none	44 teeth (with \geq 1 site with BoP and PPD \geq 5 mm)	n.r. (600 μ m)	n.r.		
	n.r.	PCP 12 (Hu-Friedy, USA) 6	methylene blue 0.005 % n.r.			
Theodoro et al. (2012)	RCT split-mouth single-center	33 patients (21 female) 43.12 \pm 8.2 (n.r.) ChP non-smokers	diode laser/GaAlAs laser (BioWave, Kondortech Equipment, São Carlos, Brazil)	30 mW 4.5 J 150 s/site 660 nm 0.4 W/cm ² 64.28 J/cm ²	test group: SRP (hand) + aPDT control group: SRP (hand)	2 – 3 – 6 OHI and professional prophylaxis (weekly in month 1, bimonthly in month 2-3, monthly in month 4-6)
	none	33 sites (BoP, PPD 5-9 mm, approximal)	fiber optic tip (n.r.)			
	examiner calibrated	PCP-UNC 15 (Hu-Friedy), occlusal stent n.r.	toluidine blue O 100 μ g/ml n.r.			none
Dilsiz et al. (2013) ^e	RCT split-mouth single-center	24 patients (14 female) 40.7 \pm 7.3 (30-58) ChP non-smokers	diode laser/AlGaAs laser (Doctor Smile diode, LAMBDA Scientifica, Vicenza, Italy)	100 mW 6 J 60 s 808 nm n.r.	test group: FM-SRP (ultrasonic) without time restriction + 1 week later SRP (hand) + aPDT control group: FM-SRP (ultrasonic) without time restriction + 1 week later SRP (hand) + placebo laser	6 professional prophylaxis after 1 and 3 mo none
	none	144 teeth distributed over three treatment groups	fiber optic tip (300 μ m)			
	examiner calibrated	Florida Probe (Gainesville, USA) with an occlusal stent n.r.	methylene blue 1 % 3 min			
Betsy et al. (2014)	RCT parallel arms single-center	88 ^a patients (44 ^a , 44 ^b) 51 female (22 ^a , 29 ^b) 40.8 \pm 8.3 ^a , 38.4 \pm 9.6 ^b ChP non-smokers	diode laser (CNI Opto-electronics Tech. Co. Ltd, Changchun, China)	1000 mW n.r. 60 s/site 655 nm n.r. 60 mW/cm ²	test group: FM-SRP (hand + ultrasonic) without time restriction + aPDT control group: FM-SRP (hand + ultrasonic) without time restriction	0.5 – 1 – 3 – 6 n.r. none
	none		fiber optic tip (200 μ m)			
	examiner calibrated	109 ^a , 120 ^b teeth (PPD 4-6 mm, single-rooted) Williams 4	methylene blue 10 mg/ml 3 min			
Malgikar et al. (2016)	RCT split-mouth single-center	24 patients (9 female) 36.73 \pm 8.46 ^c , 34.33 \pm 6.80 ^d (24-55) ChP non-smokers	diode laser (DenLase; China Daheng Group, Inc., Beijing China)	1000 mW (5.0 W peak power, with 200 μ s pulse length + 200 μ s pulse interval) n.r.	test group: FM-SRP (hand + ultrasonic) + aPDT (24 h later) control group	1 – 3 – 6 OHI after 1, 3 and 6 mo none
	none		fiber optic tip (400 μ m)			

	examiner calibrated	n.r. UNC-15, occlusal stent n.r.	methylene blue 1 % 3 min	30-45 s/site 980 nm n.r. n.r.	FM-SRP (hand + ultrasonic)	
Al-Askar et al. (2017)	RCT parallel arms single-center	70 patients (35 ^a , 35 ^b) 0 female 45.7 ± 0.8 ^a , 42.5 ± 2.6 ^b n.r.	diode laser (Periowave, Ondine Biopharma, Vancouver, Canada)	150 mW n.r. 60 s/site 670 nm	test group: FM-SRP (ultrasonic) + aPDT	3 – 6 n.r.
	none	non-smokers	flexible tip	n.r.	control group: FM-SRP (ultrasonic)	n.r.
	examiner calibrated	n.r. (≥ 6 sites with PPD ≥ 4 mm per patient) graded probe (Hu-Friedy, USA) 6	methylene blue 0.005 % n.r.			
Bundipun et al. (2018)	RCT split-mouth single-center	20 patients (13 female) 47.25 ± 8.91 (35-70) ChP non-smokers	diode laser (HELBO Photodynamic Systems, Senden, Germany)	100 mW n.r. 10 s/site (6 sites per tooth)	test group: FM-SRP (ultrasonic) + aPDT (1 week later)	1 – 3 – 6 OHI and supragingival cleaning after 1, 3 and 6 mo
	none	839 ^a , 789 ^b sites	fiber optic tip (n.r.)	660 nm n.r.	control group: FM-SRP (ultrasonic)	none
	n.r.	UNC-15 (Hu-Friedy, USA) 6	phenothiazine chloride 1 min	n.r.		
Raut et al. (2018)	RCT parallel arms single-center	50 patients* (25 ^a , 25 ^b) 22 female (9 ^a , 13 ^b) 51 ± 2.83 ^a , 46.90 ± 4.32 ^b ChP	diode laser/GaAlAs laser (n.r.)	800 mW n.r. 60 s/tooth 810 nm	test group: SRP (hand + ultrasonic) + aPDT	6 n.r.
	none	non-smokers	n.r.	n.r.	control group: SRP (hand + ultrasonic) + placebo laser	none
	examiner calibrated	n.r. University of North Carolina no15 (Hu-Friedy, USA) 6	indocyanine green 5 mg/ml 1 min	5.4 J/cm ²		

AlGaAs, aluminium-gallium-arsenide laser; BoP, bleeding on probing; ChP, chronic periodontitis; FM, full mouth; hand, hand instruments; GaAlAs, aluminium-gallium-arsenide laser; n, number; n.r., not reported; mo, months; OHI, oral hygiene instruction; aPDT, antimicrobial photodynamic therapy; PPD, probing pocket depth; RCT, randomized controlled clinical trial; SRP, scaling and root planing; ^a, test; ^b, control; ^c, males; ^d, females; ^e, study has 2 test groups see table 2; *, 5 patients lost to follow-up; #, 3 patients lost to follow-up and 2 patients discontinued intervention.

Table 5. Clinical outcome parameters of studies on adjunctive aPDT to non-surgical mechanical instrumentation. If not otherwise indicated, parameters are presented as means ± standard deviation.

First author (year)	Group	Time point	PPD (mm)	PPD change (mm)	CAL (mm)	CAL change (mm)	BOP (%)	BOP change (%)	PI (%)
Berakdar et	test	baseline	6.4 ± 0.8	-	8.1 ± 1.3	-	100 ^e	-	-

Theodoro et al. (2012)		6 mo	-	2.9 ± 0.8*	-	-	13.6 ^c	-	-
	control	baseline	5.9 ± 0.8	-	7.2 ± 1.2	-	100 ^e	-	-
		6 mo	-	2.4 ± 0.6	-	-	22.7 ^c	-	-
	test	baseline	5.75 ± 1.44	-	6.52 ± 2.11	-	93.9	-	90.9
Dilsiz et al. (2013)		6 mo	3.42 ± 1.15	-	4.96 ± 2.07	-	45.5	-	27.3
	control	baseline	5.81 ± 1.0	-	6.23 ± 1.25	-	97.0	-	93.9
		6 mo	3.1 ± 0.83	-	4.25 ± 1.73	-	27.3	-	15.2
	test	baseline	5.88 ± 0.74	-	7.67 ± 0.56	-	88 ± 0.34	-	1.50 ± 0.51 ^d
Betsy et al. (2014)		6 mo	4.33 ± 0.48	1.54 ± 0.59	6.13 ± 0.99	1.54 ± 1.10	38 ± 0.49	-	0.79 ± 0.41 ^d
	control	baseline	5.83 ± 0.76	-	7.50 ± 0.72	-	92 ± 0.28	-	1.46 ± 0.51 ^d
		6 mo	4.42 ± 0.88	1.42 ± 0.88	6.04 ± 1.00	1.50 ± 0.88	46 ± 0.51	-	0.71 ± 0.46 ^d
	test	baseline	5.7 (5.0-6.0;1.0) ^a	-	6.5 (5.0-8.0;1.4) ^a	-	-	-	2.0 (0.5-3.0;0.8) ^{a,c*}
Malgikar et al. (2016)		6 mo	3.0 (2.0-6.0;1.0) ^{a*}	-	4.0 (2.6-7.0;2.0) ^{a*}	-	-	-	1.0 (0.0-2.5;1.0) ^{a,c}
	control	baseline	5.5 (4.2-6.0;1.0) ^a	-	6.0 (4.2-8.0;1.7) ^a	-	-	-	1.2 (0.5-3.0;1.0) ^{a,c*}
		6 mo	4.0 (2.0-6.0;1.0) ^{a*}	-	4.5 (2.0-7.0;2.0) ^{a*}	-	-	-	0.5 (0.0-2.0;0.5) ^{a,c}
	test	baseline	6.13 ± 0.38	-	6.59 ± 0.50	-	-	-	2.54 ± 1.70 ^e
Al-Askar et al. (2017)		6 mo	3.57 ± 0.41*	2.57 ± 0.53	4.04 ± 0.37	2.55 ± 0.44	-	-	1.73 ± 0.49 ^e
	control	baseline	6.16 ± 0.40	-	6.63 ± 0.53	-	-	-	2.49 ± 1.73 ^e
		6 mo	3.65 ± 0.49*	2.50 ± 0.54	4.00 ± 0.39	2.63 ± 0.47	-	-	1.60 ± 0.52 ^e
	test	baseline	15.8 ± 3.4 ^b	-	-	-	51.6 ± 7.9	-	54.4 ± 8.4
Bundidpun et al. (2018)		6 mo	10.4 ± 2.5 ^b	-	-	-	40.3 ± 5.6	-	42.5 ± 6.7
	control	baseline	17.2 ± 3.4 ^b	-	-	-	56.4 ± 9.3	-	51.6 ± 7.5
		6 mo	13.6 ± 2.8 ^b	-	-	-	44.5 ± 8.2	-	47.2 ± 7.4
	test	baseline	4.96 ± 1.11	-	5.15 ± 1.56	-	85.50	-	3.01 ± 1.07 ^f
Raut et al. (2018)		6 mo	2.97 ± 0.74	1.99 ± 0.89	3.99 ± 1.23	1.16 ± 1.16	33.30*	52.20	2.06 ± 1.09 ^f
	control	baseline	4.91 ± 1.02	-	5.01 ± 1.57	-	83.60	-	3.02 ± 1.08 ^f
		6 mo	3.02 ± 0.81	1.89 ± 0.92	3.89 ± 1.33	1.12 ± 1.16	40.50*	43.10	2.15 ± 1.06 ^f
	test	baseline	6.04 ± 0.82	-	5.80 ± 0.70	-	100	-	1.52 ± 0.46 ^e
		6 mo	3.53 ± 0.58**	-	4.12 ± 0.78**	-	10*	-	0.60 ± 0.47 ^e
	control	baseline	6.08 ± 0.73	-	5.68 ± 0.69	-	100	-	1.48 ± 0.44 ^e
		6 mo	5.08 ± 0.66**	-	4.96 ± 0.73**	-	40*	-	0.68 ± 0.45 ^e

BOP, bleeding on probing; CAL, clinical attachment loss; PI, plaque index; PPD, probing pocket depth; *, p<0.05; **, p<0.001; ^a, median (range;inter-quartile range); ^b, number of sites with PPD ≥ 4 mm; ^c, % cases with ≥ 1 tooth with BOP; ^d, according to Løe (1967); ^e, according to Silness & Løe (1964); ^f, Turesky modification of Quigley & Hein (1962).

Table 6a. Frequency of reported secondary outcomes of included articles on adjunctive laser therapy.

First author (year)	CAL change	BoP change	Plaque Index change	Residual PPD	Change in subgingival biofilm composition	Changes in GCF biomarker levels/volumes	PROMS	Harms or adverse effects
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Üstün et al. (2018)	+	+	+	NR	NR	+	NR	NR
Matarese et al. (2017)	+	+	+	NR	+	+	NR	NR
Hatipoglu et al. (2017)	+	+	+	NR	NR	NR	NR	NR
Dereci et al. (2016)	+	+	+	NR	+	NR	NR	+
Euzebio Alves et al. (2013)	+	+	+	+	+	NR	NR	NR
Dilsiz et al. (2013)	+	+	+	NR	NR	NR	NR	+
Eltas & Orbak (2012a)	+	NR	+	NR	NR	+	NR	NR
Kelbauskiene et al. (2011)	+	+	NR	NR	NR	NR	NR	+
Rotundo et al. (2010)	+	+	+	NR	NR	NR	+	+
Kamma et al. (2009)	+	+	+	NR	+	NR	NR	NR
Total	10 (100%)	9 (90%)	9 (90%)	1 (10%)	4 (40%)	3 (30%)	1 (10%)	4 (40%)

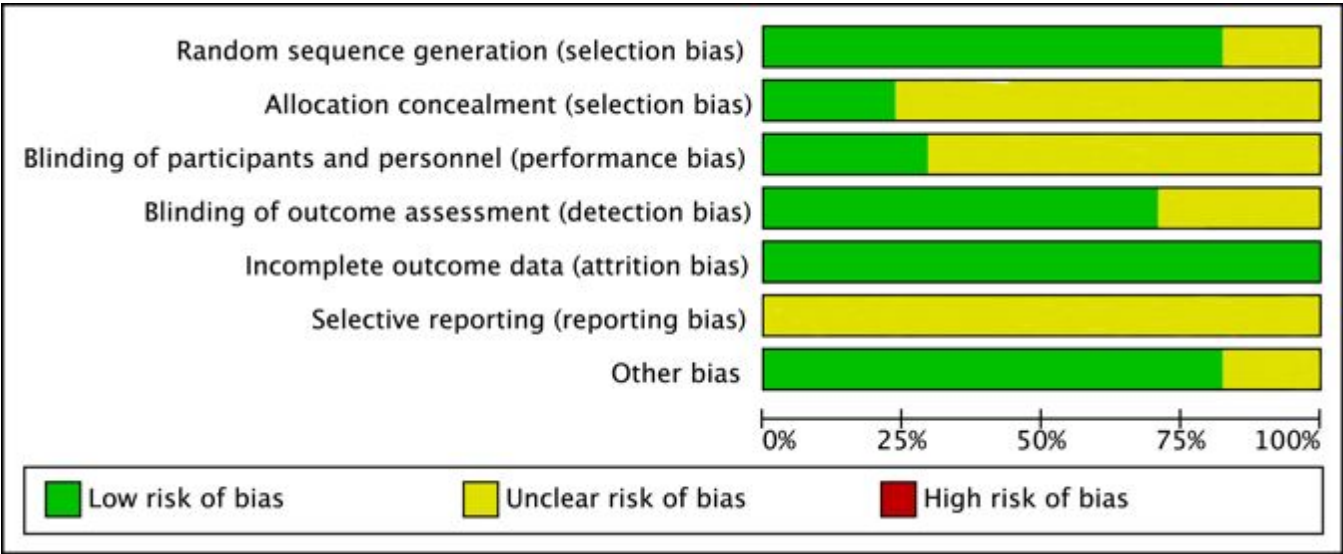
PPD Probing Pocket Depth
 CAL Clinical Attachment Level
 BoP Bleeding on Probing
 GCF Gingival Crevicular Fluid
 PROMs Patient-Reported Outcome Measures
 NR Outcome not reported
 + Outcome reported

Table 6b. Frequency of reported secondary outcomes of included articles on adjunctive antimicrobial photodynamic therapy (aPDT).

First author (year)	CAL change	BoP change	Plaque Index change	Residual PPD	Changes in subgingival biofilm composition	Changes in GCF biomarker levels/volumes	PROMs	Harms or adverse effects
Raut et al. (2018)	+	+	+	NR	+	NR	NR	+
Bundipun et al. (2018)	+	+	+	+	NR	NR	NR	+
Al-Askar et al. (2017)	NR	+	+	NR	NR	NR	NR	NR
Malgikar et al. (2016)	+	NR	+	NR	NR	NR	NR	+
Betsy et al. (2014)	+	NR	+	NR	NR	NR	+	+
Dilsiz et al. (2013)	+	+	+	NR	NR	NR	NR	+
Berakdar et al. (2012)	+	+	+	NR	NR	NR	NR	+
Theodoro et al. (2012)	+	+	+	NR	+	NR	NR	+
Total	7 (88%)	6 (75%)	8 (100%)	1 (13%)	2 (25%)	0 (0%)	1 (13%)	7 (88%)

PPD Probing Pocket Depth
 CAL Clinical Attachment Level
 BoP Bleeding on Probing
 GCF Gingival Crevicular Fluid
 PROMs Patient-Reported Outcome Measures
 NR Outcome not reported
 + Outcome reported

Table 7a+b. Parameters provided in the Cochrane Center and CONSORT guidelines (Consolidated Standards of Reporting Trials) to evaluate the quality of randomized controlled trials (RCTs).



	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Other bias
Al-Askar et al. 2017	?	+	?	?	+	?	+
Berakdar et al. 2012	+	?	?	+	+	?	+
Betsy et al. 2014	+	+	?	+	+	?	+
Bundipun et al. 2018	+	?	?	+	+	?	+
Dereci et al. 2016	+	?	+	+	+	?	+
Dilsiz et al. 2013	+	?	+	+	+	?	+
Eltas and Orbak 2012a	?	?	?	?	+	?	+
Euzebio Alves et al. 2013	+	?	+	+	+	?	+
Hatipoglu et al. 2017	?	?	?	?	+	?	?
Kamma et al. 2009	+	?	?	?	+	?	+
Kelbauskiene et al. 2011	+	?	?	+	+	?	?
Malgikar et al. 2016	+	?	+	+	+	?	?
Matarese et al. 2017	+	+	+	+	+	?	+
Raut et al. 2018	+	?	?	+	+	?	+
Rotundo et al. 2010	+	+	?	+	+	?	+
Theodoro et al. 2012	+	?	?	+	+	?	+
Ustun et al. 2018	+	?	?	?	+	?	+

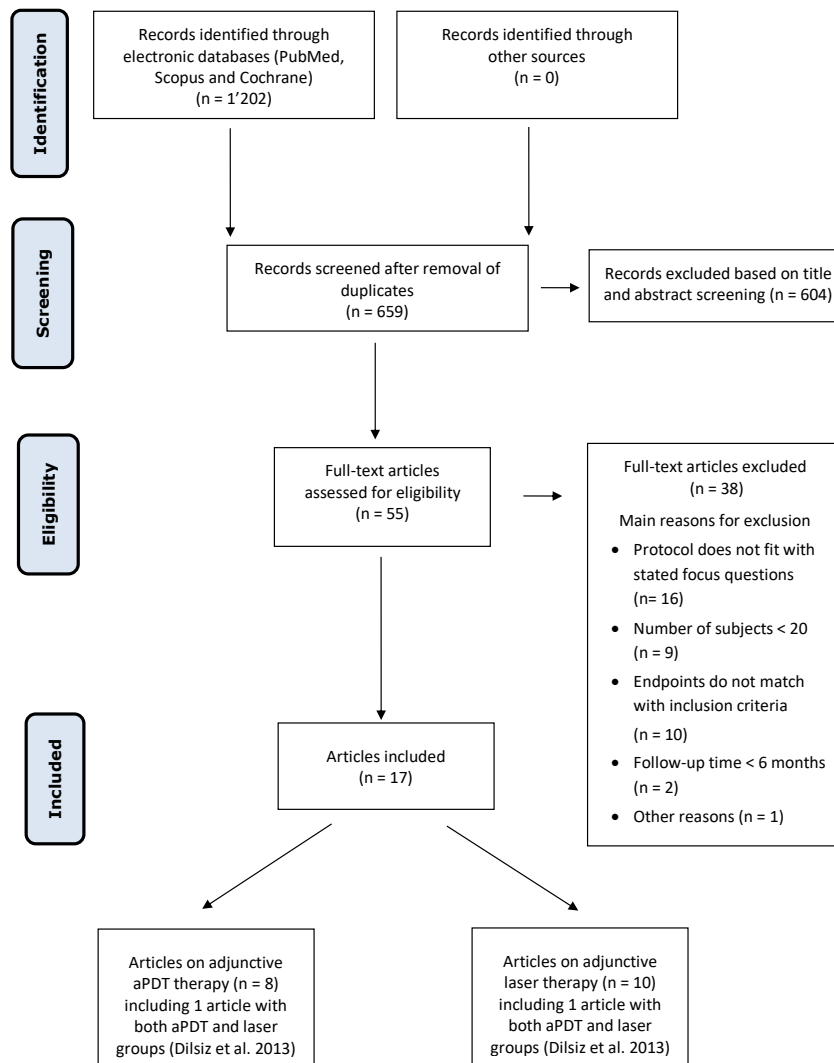
Figure 1. PRISMA flow chart depicting the selection process.

Figure 2. Forest plot of the weighted mean change in PPD at 6 months with adjunctive aPDT with diode lasers (wavelength range 650-700 nm; test) compared with non-surgical mechanical instrumentation alone (control).

